FRAMEWORK FOR ANNUAL REPORT OF STATE CHILDREN'S HEALTH INSURANCE PLANS UNDER TITLE XXI OF THE SOCIAL SECURITY ACT

Preamble

Section 2108(a) of the Act provides that the State must assess the operation of the State child health plan in each fiscal year, and report to the Secretary, by January 1 following the end of the fiscal year, on the results of the assessment. In addition, this section of the Act provides that the State must assess the progress made in reducing the number of uncovered, low-income children.

To assist states in complying with the statute, the National Academy for State Health Policy (NASHP), with funding from the David and Lucile Packard Foundation, has coordinated an effort with states to develop a framework for the Title XXI annual reports.

The framework is designed to:

- Recognize the ***diversity*** of State approaches to SCHIP and allow States ***flexibility*** to highlight key accomplishments and progress of their SCHIP programs, **AND**

- Provide ***consistency*** across States in the structure, content, and format of the report, **AND**

- Build on data ***already collected*** by HCFA quarterly enrollment and expenditure reports, **AND**

- Enhance ***accessibility*** of information to stakeholders on the achievements under Title XXI.

FRAMEWORK FOR ANNUAL REPORT
OF STATE CHILDREN'S HEALTH INSURANCE PLANS
UNDER TITLE XXI OF THE SOCIAL SECURITY ACT

State/Territory: **Vermont**

The following Annual Report is submitted in compliance with Title XXI of the Social Security Act (Section 2108(a)).

Eileen Elliot, Commissioner

SCHIP Program Name (s) **Dr. Dynasaur**

SCHIP Program Type ____Medicaid SCHIP Expansion Only
__X__Separate SCHIP Program Only
____Combination of the above

Reporting Period **Federal Fiscal Year 2000 (10/1/99-9/30/00)**

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_____

Submission Date_____

SECTION 1. DESCRIPTION OF PROGRAM CHANGES AND PROGRESS

This sections has been designed to allow you to report on your SCHIP program? s changes and progress during Federal fiscal year 2000 (September 30, 1999 to October 1, 2000).

1.1 Please explain changes your State has made in your SCHIP program since September 30, 1999 in the following areas and explain the reason(s) the changes were implemented.

Note: If no new policies or procedures have been implemented since September 30, 1999, please enter ***?****NC****?*** *for no change. If you explored the possibility of changing/implementing a new or different policy or procedure but did not, please explain the reason(s) for that decision as well.*

1. Program eligibility **NC**
2. Enrollment process **NC**
3. Presumptive eligibility **NC**
4. Continuous eligibility **NC**
5. Outreach/marketing campaigns **NC**
6. Eligibility determination process **NC**
7. Eligibility redetermination process **NC**
8. Benefit structure **NC**
9. Cost-sharing policies **- effective 10/1/99 program fees increased to $25 per month/per family**
10. Crowd-out policies **NC**
11. Delivery system **- Vermont implemented a Primary Care Case Management (PCCM) program effective 10/1/99. An amendment request was submitted 11/24/99 to enroll SCHIP eligibles into our PCCM (PC Plus) and approval was received on 2/28/00.**
12. Coordination with other programs (especially private insurance and Medicaid) **NC**
13. Screen and enroll process **NC**

14. Application **NC**

15. Other

1.2 Please report how much progress has been made during FFY 2000 in reducing the number of uncovered, low-income children.

1. Please report the changes that have occurred to the number or rate of uninsured, low-income children in your State during FFY 2000. Describe the data source and method used to derive this information. **In 1997 the estimated number of uninsured was 6,047. On 9/30/99 there were 1,271 children enrolled and by the end of 9/00 2,107. The data source is an eligibility report that is created monthly from our eligible files.**

2. How many children have been enrolled in Medicaid as a result of SCHIP outreach activities and enrollment simplification? Describe the data source and method used to derive this information**. As of 9/30/00 2,107. The data source is the same as the above.**

3. Please present any other evidence of progress toward reducing the number of uninsured, low-income children in your State. **As part of a HRSA sponsored initiative the State of Vermont is currently conducting a survey to determine the number of uninsured.**

4. Has your State changed its baseline of uncovered, low-income children from the number reported in your March 2000 Evaluation?

   X No, skip to 1.3

   ____ Yes, what is the new baseline?

   What are the data source(s) and methodology used to make this estimate?

   What was the justification for adopting a different methodology?

   What is the State**?** s assessment of the reliability of the estimate? What are the limitations of the data or estimation methodology? (Please provide a numerical range or confidence intervals if available.)

   Had your state not changed its baseline, how much progress would have been made in reducing the number of low-income, uninsured children?

1.3 Complete Table 1.3 to show what progress has been made during FFY 2000 toward

achieving your State's strategic objectives and performance goals (as specified in your State Plan).

In Table 1.3, summarize your State's strategic objectives, performance goals, performance measures and progress towards meeting goals, as specified in your SCHIP State Plan. Be as specific and detailed as possible. Use additional pages as necessary. The table should be completed as follows:

Column 1:	List your State's strategic objectives for your SCHIP program, as specified in your State Plan.
Column 2:	List the performance goals for each strategic objective.
Column 3:	For each performance goal, indicate how performance is being measured, and progress towards meeting the goal. Specify data sources, methodology, and specific measurement approaches (e.g., numerator, denominator). Please attach additional narrative if necessary.

Note: *If no new data are available or no new studies have been conducted since what was reported in the March 2000 Evaluation, please complete columns 1 and 2 and enter 'NC' (for no change) in column 3.*

Table 1.3

(1) Strategic Objectives (as specified in Title XXI State Plan and listed in your March Evaluation)	(2) Performance Goals for each Strategic Objective	(3) Performance Measures and Progress (Specify data sources, methodology, time period, etc.)
OBJECTIVES RELATED TO REDUCING THE NUMBER OF UNINSURED CHILDREN		
Reduce the number of uninsured children in the State	**Reduce the percentage of uninsured children from 4% to 3% by FFY 2001**	Data Sources: **Vermont MMIS** Methodology: Progress Summary: **Current enrollees have grown from 1,271 on 9/30/99 to 2,107 on 9/30/00. By the close of FFY 2001 we should have the results of the HRSA survey to compare to the current number of enrollees.**
OBJECTIVES RELATED TO SCHIP ENROLLMENT		
Improve Access to Care	**Increase access by enrolling SCHIP children in MCO's where each eligible will have access to a primary care physician**	Data Sources: **Vermont MMIS** Methodology: **Compare the number of PCCM enrollees to the FFS enrollees.** Progress Summary: **As of 9/30/00 50.4% are enrolled in the PCCM. As previously reported we discontinued enrolling new eligibles in MCO's effective 7/1/99. We began enrolling new eligibles into the PCCM starting 9/00. Currently 1,062 are enrolled in the PCCM and 1,045 are in FFS.**
OBJECTIVES RELATED TO INCREASING MEDICAID ENROLLMENT		
Improve service coordination through Managed Care enrollment.	**Our goal is to enroll 60% of all SCHIP children into an MCO no later than the second month after eligibility determination and the remainder of**	Data Sources: Methodology: **NC** Progress Summary:

Table 1.3

(1) Strategic Objectives (as specified in Title XXI State Plan and listed in your March Evaluation)	(2) Performance Goals for each Strategic Objective	(3) Performance Measures and Progress (Specify data sources, methodology, time period, etc.)
	participants no later than the third month	
OBJECTIVES RELATED TO INCREASING ACCESS TO CARE (USUAL SOURCE OF CARE, UNMET NEED)		
Improve care through the offering of health insurance	**To increase the percentage of 2 year old children who are fully immunized from 84% to 90%**	Data Sources: Methodology: **NC** Progress Summary:
OBJECTIVES RELATED TO USE OF PREVENTIVE CARE (IMMUNIZATIONS, WELL-CHILD CARE)		
		Data Sources: Methodology: Progress Summary:
OTHER OBJECTIVES		
		Data Sources: Methodology: Progress Summary:

1.4 If any performance goals have not been met, indicate the barriers or constraints to meeting them. There is no indication that performance goals have not been met.

1.5 Discuss your State's progress in addressing any specific issues that your state agreed to assess in your State plan that are not included as strategic objectives. NA

1.6 Discuss future performance measurement activities, including a projection of when additional data are likely to be available. By the close of FFY 2001 we should have results from the HRSA survey to compare to the number of enrollees.

1.7 Please attach any studies, analyses or other documents addressing outreach, enrollment, access, quality, utilization, costs, satisfaction, or other aspects of your SCHIP program's performance. Please list attachments here. The same studies and analysis activities that apply to Medicaid apply to SCHIP. The level of participation for our higher income level beneficiaries who have proven to be generally low users does not justify a particular effort.
Attached is a copy of our 2000 Customer Satisfaction Survey.

SECTION 2. AREAS OF SPECIAL INTEREST

This section has been designed to allow you to address topics of current interest to stakeholders, including; states, federal officials, and child advocates.

2.1 Family coverage: NA

A. If your State offers family coverage, please provide a brief narrative about requirements for participation in this program and how this program is coordinated with other program(s). Include in the narrative information about eligibility, enrollment and redetermination, cost sharing and crowd-out.

2. How many children and adults were ever enrolled in your SCHIP family coverage program during FFY 2000 (10/1/99 -9/30/00)?

   Number of adults_____
   Number of children_____

3. How do you monitor cost-effectiveness of family coverage?

2.2 Employer-sponsored insurance buy-in: NA

1. If your State has a buy-in program, please provide a brief narrative about requirements for participation in this program and how this program is coordinated with other SCHIP program(s).

2. How many children and adults were ever enrolled in your SCHIP ESI buy-in program during FFY 2000?

   Number of adults_____
   Number of children_____

2.3 Crowd-out:

1. How do you define crowd-out in your SCHIP program? **One month waiting period. Children with insurance coverage at the same income level are eligible as Medicaid/Dr Dynasaur under the 1115 waiver with a reduced premium.**

2. How do you monitor and measure whether crowd-out is occurring? **With the size of our SCHIP program there is no justification for a special effort to monitor crowd-out.**

3. What have been the results of your analyses? Please summarize and attach any available reports or other documentation. **See above response.**

4. Which anti-crowd-out policies have been most effective in discouraging the substitution of public coverage for private coverage in your SCHIP program? Describe the data source and method used to derive this information. **NA**

2.4 Outreach:

1. What activities have you found most effective in reaching low-income, uninsured children? How have you measured effectiveness? **Outreach activities target all kids under 18. There are no special efforts made for only the SCHIP population. As of 9/00 the number of kids under 18 enrolled were 55,358 of which 2,107 were SCHIP eligibles.**

2. Have any of the outreach activities been more successful in reaching certain populations (e.g., minorities, immigrants, and children living in rural areas)? How have you measured effectiveness? **See above response.**

3. Which methods best reached which populations? How have you measured effectiveness? **See above response.**

2.5 Retention:

1. What steps are your State taking to ensure that eligible children stay enrolled in Medicaid and SCHIP? **Automatic reminder notices are sent to those who do not return the required recertification form by the first deadline. Education of the Regional Partnerships on the recertification process and how they can help support this.**

2. What special measures are being taken to reenroll children in SCHIP who disenroll, but are still eligible?

___ Follow-up by caseworkers/outreach workers
__**X**__ Renewal reminder notices to all families
___ Targeted mailing to selected populations, specify population _____
__**X**__ Information campaigns
___ Simplification of re-enrollment process, please describe _____
__**X**__ Surveys or focus groups with disenrollees to learn more about reasons for disenrollment, please describe **The HRSA survey may give us this information**
___ Other, please explain_____

3. Are the same measures being used in Medicaid as well? If not, please describe the differences. **Yes.**

4. Which measures have you found to be most effective at ensuring that eligible children stay enrolled? **NA**

5. What do you know about insurance coverage of those who disenroll or do not reenroll in SCHIP (e.g., how many obtain other public or private coverage, how many remain uninsured?) Describe the data source and method used to derive this information.
   The HRSA survey may provide us with this information.

2.6 Coordination between SCHIP and Medicaid:

1. Do you use common application and redetermination procedures (e.g., the same verification and interview requirements) for Medicaid and SCHIP? Please explain. **Yes. SCHIP and VT's Medicaid/Dr. Dynasaur program are fully integrated . Families apply using the same application form, processing staff are trained in all health care programs, and the computer system tests for eligibility and interfaces with other programs.**

2. Explain how children are transferred between Medicaid and SCHIP when a child**?**s eligibility status changes.
   The process is transparent to participants. Change in the category code and billing for premiums (over 185%) are the only differences.

3. Are the same delivery systems (including provider networks) used in Medicaid and SCHIP? Please explain.**Yes. All beneficiaries get the same program cards, assess care through the same benefit delivery systems, see the same providers, and get the same services. Only category codes assigned at the person level based on the eligibility determination distinguish the funding of the care and these are not apparent or even important to the eligibles.**

2.7 Cost Sharing:

1. Has your State undertaken any assessment of the effects of premiums/enrollment fees on participation in SCHIP? If so, what have you found? **We have not done any assessment.**

2. Has your State undertaken any assessment of the effects of cost-sharing on utilization of health service under SCHIP? If so, what have you found? **Vermont does not have any cost-sharing on services.**

2.8 Assessment and Monitoring of Quality of Care:

1. What information is currently available on the quality of care received by SCHIP enrollees? Please summarize results. **Two focused study briefs are attached: Diabetes Care and Pediatric Asthma Care. Both studies use data on all Medicaid eligibles not just SCHIP.**

2. What processes are you using to monitor and assess quality of care received by SCHIP enrollees,

particularly with respect to well-baby care, well-child care, immunizations, mental health, substance abuse counseling and treatment and dental and vision care? **None at this time.**

3. What plans does your SCHIP program have for future monitoring/assessment of quality of care received by SCHIP enrollees? When will data be available?

SECTION 3. SUCCESSES AND BARRIERS

This section has been designed to allow you to report on successes in program design, planning, and implementation of your State plan, to identify barriers to program development and implementation, and to describe your approach to overcoming these barriers.

3.1 Please highlight successes and barriers you encountered during FFY 2000 in the following areas. Please report the approaches used to overcome barriers. Be as detailed and specific as possible.

Note: If there is nothing to highlight as a success or barrier, Please enter "NA" for not applicable.

1. Eligibility **NA**
2. Outreach **NA**
3. Enrollment **NA**
4. Retention/disenrollment **NA**
5. Benefit structure **NA**
6. Cost-sharing **NA**
7. Delivery systems **NA**
8. Coordination with other programs **NA**
9. Crowd-out **NA**
10. Other

SECTION 4. PROGRAM FINANCING

This section has been designed to collect program costs and anticipated expenditures.

4.1 Please complete Table 4.1 to provide your budget for FFY 2000, your current fiscal year budget, and FFY 2002 projected budget. Please describe in narrative any details of your planned use of funds.

Note: Federal Fiscal Year 2000 starts 10/1/99 and ends 9/30/00).

	Federal Fiscal Year 2000 costs	Federal Fiscal Year 2001	Federal Fiscal Year 2002
Benefit Costs			
Insurance payments			
Managed care	393,604	1,223,744	1,641,526
per member/per month rate X # of eligibles			
Fee for Service	1,619,537	804,757	912,736
Total Benefit Costs	2,013,141	2,028,501	2,554,262
(Offsetting beneficiary cost sharing payments)	(220,606)	(222,000)	(275,000)
Net Benefit Costs	1,792,535	1,806,501	2,279,262
Administration Costs			
Personnel	36,910	37,033	46,725
General administration	32,298	32,517	41,027
Contractors/Brokers (e.g., enrollment contractors)			
Claims Processing	58,638	59,073	74,532
Outreach/marketing costs	24,011	24,026	30,314
Other			
Total Administration Costs	151,857	152,649	192,598
10% Administrative Cost Ceiling			
Federal Share (multiplied by enhanced FMAP rate)	1,430,488	1,443,502	1,832,637
State Share	513,904	515,648	639,223
TOTAL PROGRAM COSTS	**1,944,392**	**1,959,150**	**2,471,860**

4.2 Please identify the total State expenditures for family coverage during Federal fiscal year 2000. NA

4.3 What were the non-Federal sources of funds spent on your CHIP program during FFY 2000?

_X_ State appropriations
____ County/local funds
____ Employer contributions
____ Foundation grants
____ Private donations (such as United Way, sponsorship)
____ Other (specify) _____

A. Do you anticipate any changes in the sources of the non-Federal share of plan expenditures.

No.

SECTION 5: SCHIP PROGRAM AT-A-GLANCE

This section has been designed to give the reader of your annual report some context and a quick glimpse of your SCHIP program.

5.1 To provide a summary at-a-glance of your SCHIP program characteristics, please provide the following information. If you do not have a particular policy in-place and would like to comment why, please do. (Please report on initial application process/rules)

Table 5.1	**Medicaid Expansion SCHIP program**	**Separate SCHIP program**
Program Name		**Dr. Dynasaur**
Provides presumptive eligibility for children	_____No _____Yes, for whom and how long?	__X__No _____Yes, for whom and how long?
Provides retroactive eligibility	_____No _____Yes, for whom and how long?	_____No __X__Yes, for whom and how long? **3 months**
Makes eligibility determination	_____State Medicaid eligibility staff _____Contractor _____Community-based organizations _____Insurance agents _____MCO staff _____Other *(specify)* _____	__X__State Medicaid eligibility staff _____Contractor _____Community-based organizations _____Insurance agents _____MCO staff _____Other *(specify)* _____
Average length of stay on program	Specify months _____	Specify months _____
Has joint application for Medicaid and SCHIP	_____No _____Yes	_____No __X__Yes
Has a mail-in application	_____No _____Yes	_____No __X__Yes
Can apply for program over phone	_____No _____Yes	__X__No _____Yes
Can apply for program over internet	_____No _____Yes	_____No __X__Yes **interview to follow**

Table 5.1	Medicaid Expansion SCHIP program	Separate SCHIP program
Requires face-to-face interview during initial application	_____No _____Yes	___**X**__No _____Yes
Requires child to be uninsured for a minimum amount of time prior to enrollment	_____No _____Yes, specify number of months _____ What exemptions do you provide?	_____No ___**X**__Yes, specify number of months _**1**_____ What exemptions do you provide?
Provides period of continuous coverage <u>regardless of income changes</u>	_____No _____ Yes, specify number of months _____ Explain circumstances when a child would lose eligibility during the time period	_____No _____Yes, specify number of months _____ Explain circumstances when a child would lose eligibility during the time period
Imposes premiums or enrollment fees	_____No _____Yes, how much? _____ Who Can Pay? ___ Employer ___ Family ___ Absent parent ___ Private donations/sponsorship ___ Other (specify) _____	_____No __**X**__Yes, how much? **<u>$25 per household per month billed quarterly</u>**_____ Who Can Pay? _**X**__ Employer _**X**__ Family _**X**__ Absent parent _**X**__ Private donations/sponsorship ___ Other (specify) _____
Imposes copayments or coinsurance	_____No _____Yes	_**X**__No _____Yes
Provides preprinted redetermination process	_____ No _____ Yes, we send out form to family with their information precompleted and: ___ ask for a signed confirmation that information is still correct ___ do not request response unless income or other circumstances have changed	__**X**___ No _____ Yes, we send out form to family with their information and: ___ ask for a signed confirmation that information is still correct ___ do not request response unless income or other circumstances have changed

5.2 Please explain how the redetermination process differs from the initial application process.

The process to redetermine eligibility differs in that recipients are mailed a redetermination letter and a short application form six weeks before the end of the certification period. If the form isn't received within three weeks, a reminder is sent.

SECTION 6: INCOME ELIGIBILITY

This section is designed to capture income eligibility information for your SCHIP program.

6.1 As of September 30, 2000, what was the income standard or threshold, as a percentage of the Federal poverty level, for countable income for each group? If the threshold varies by the child**?**s age (or date of birth), then report each threshold for each age group separately. Please report the threshold af17er application of income disregards.

Title XIX Child Poverty-related Groups or Section 1931-whichever category is higher	____% of FPL for children under age _____ ____% of FPL for children aged _____ ____% of FPL for children aged _____
Medicaid SCHIP Expansion	____% of FPL for children aged _____ ____% of FPL for children aged _____ ____% of FPL for children aged _____
State-Designed SCHIP Program	**225-300%** of FPL for children aged **__up to 18**_____ ____% of FPL for children aged _____ ____% of FPL for children aged _____

6.2 As of September 30, 2000, what types and *amounts* of disregards and deductions does each program use to arrive at total countable income? *Please indicate the amount of disregard or deduction used when determining eligibility for each program. If not applicable, enter "NA."*

Do rules differ for applicants and recipients (or between initial enrollment and redetermination) ____ Yes __**X**__ No
If yes, please report rules for applicants (initial enrollment).

Table 6.2

	Title XIX Child Poverty-related Groups	Medicaid SCHIP Expansion	State-designed SCHIP Program
Earnings	$	$	$ **90**
Self-employment expenses	$	$	$**90 + deprecation**
Alimony payments Received	$	$	$**NA**
Paid	$	$	$**NA**
Child support payments Received	$	$	$**50 exclusion per household**
Paid	$	$	$**NA**
Child care expenses	$	$	$**200 maximum**
Medical care expenses	$	$	$**NA**
Gifts	$	$	$**NA**
Other types of disregards/deductions (specify)	$	$	$

6.3 For each program, do you use an asset test?

Title XIX Poverty-related Groups __ No ____Yes, specify countable or allowable level of asset test_____
Medicaid SCHIP Expansion program ___No ____Yes, specify countable or allowable level of asset test_____
State-Designed SCHIP program __**X**__No ____Yes, specify countable or allowable level of asset test_____
Other SCHIP program_____ ____No ____Yes, specify countable or allowable level of asset test_____

6.4 Have any of the eligibility rules changed since September 30, 2000? ___ Yes **_X__** No

SECTION 7: FUTURE PROGRAM CHANGES

This section has been designed to allow you to share recent or anticipated changes in your SCHIP program.

7.1 What changes have you made or are planning to make in your SCHIP program during FFY 2001(10/1/00 through 9/30/01)? Please comment on why the changes are planned.

1. Family coverage

2. Employer sponsored insurance buy-in

3. 1115 waiver

4. Eligibility including presumptive and continuous eligibility

5. Outreach

6. Enrollment/redetermination process

7. Contracting

8. Other **Vermont has an approval to increase program fees (premiums) from the current $25 per household per month to $50 per household per month pending implementation.**

EQRO Focused Study Brief:
Pediatric Asthma Care

Prepared by:

The Delmarva Foundation for Medical Care and
The Office of Vermont Health Access

This report presents an analysis of the Vermont Medicaid Administrative Database. The information presented here is based on a quarterly analysis (calendar quarters starting with the first quarter of 1996) of the experience of Vermont Medicaid beneficiaries that are enrolled for the entire quarter.

The data and information presented in this report are designed to facilitate continuous quality improvement efforts by the provider organizations. Indicators may not be comparable across plans and the fee-for-service setting because of differences in the population served (age structure, co-morbidities, and disease severity) that remain unaccounted for by the analysis.

The methodological approach presented in this document was developed by the Delmarva Foundation for Medical Care and the Office of Vermont Health Access. The specific definitions and quality indicators were developed by the Pediatric Asthma Work Group as convened by the Vermont Program for Quality in Health Care. This workgroup had broad statewide participation with representative from both of the Medicaid Managed Care Organizations.

Pediatric Asthma

Asthma is a chronic inflammatory disorder with inflammation caused by allergens or other stimuli leading to acute difficulty breathing (bronchial hyperresponsiveness) and obstruction to airflow. Under-treatment and inappropriate therapy are major contributors to asthma morbidity and mortality in the United States. Hospitalizations due to asthma are preventable or avoidable when patients receive appropriate primary care.

Performance Measures

VPQHC's Pediatric Asthma Work Group developed the criteria for identifying asthmatics and measuring various aspects of the quality of care received by asthmatics.

A child is identified as "asthmatic" if s/he has any one of the following events at anytime:

- One hospital discharge coded as asthma (493.xx)
- One prescription for inhaled chromalyn
- One prescription for inhaled steroid
- One prescription for leukotriene agonists

Or a child may be identified as "asthmatic" if s/he has any of the following events in any combination of two (even two of the same event) within a year, separated by 30 days:

- An emergency room visit coded asthma (493.xx)
- An ambulatory visit coded asthma (493.xx)
- A prescription for a beta-agonist

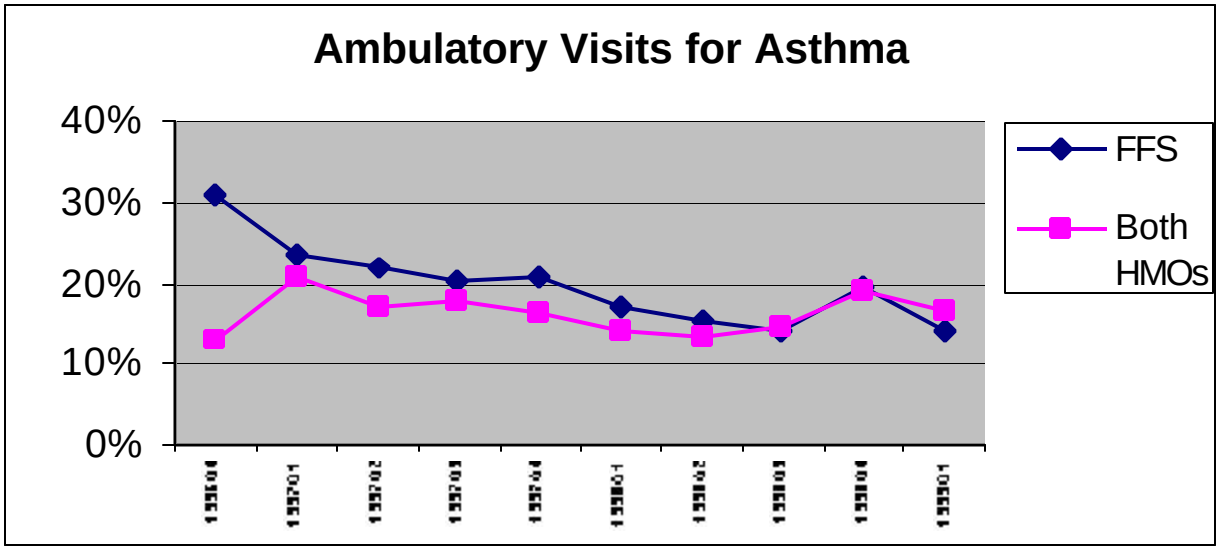
The Pediatric Asthma Care Project compares the fee-for-service experience to the managed care experience by asking five questions about quality of care. Those questions are:

- How many asthmatics receive a primary care (ambulatory) visit?
- How many asthmatics use beta-agonists (acute rescue medication)?
- How many asthmatics use anti-inflammatories (maintenance medication)?
- How many asthmatics use leukotriene antagonists (newer class of maintenance medication)?
- How many asthmatics use theophyllines?
- How many asthmatics utilize the emergency room?
- How many asthmatics are discharged from the hospital?

Þ The assumption behind these questions is that appropriate use of ambulatory care and medications should reduce the need for hospital services (emergency room utilization and inpatient stays) for asthma.

Quality Indicator 1. What percentage of asthmatics have at least one primary care (ambulatory) encounter during a given calendar quarter?

Numerator: All continuously enrolled and eligible identified asthmatics with at least one ambulatory encounter for asthma care (coded 493.xx).
Denominator: All continuously enrolled and eligible identified asthmatics.



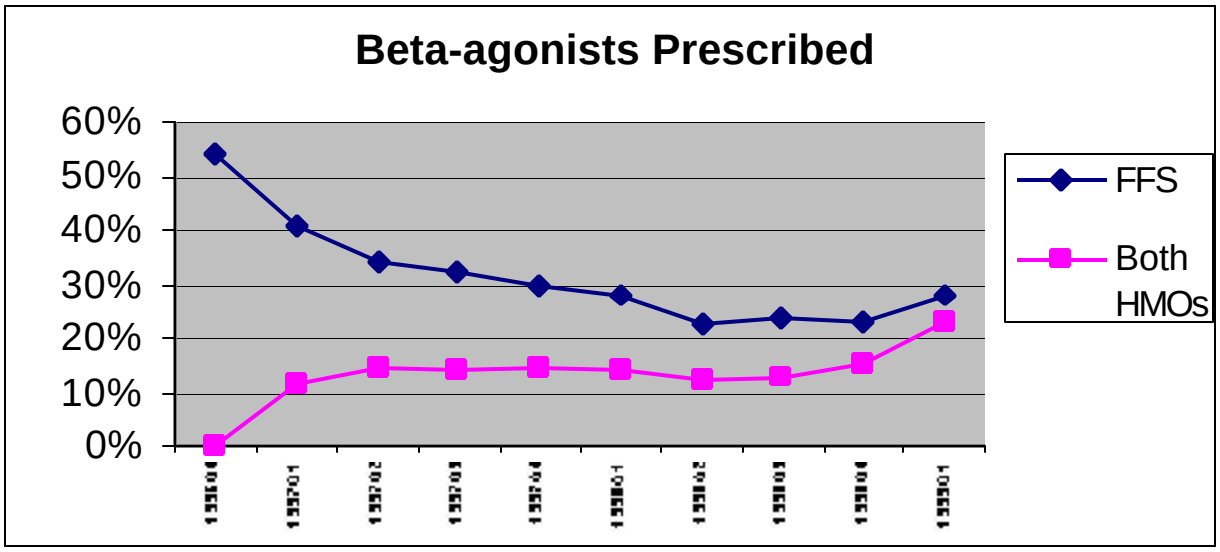
Key findings:

- Identified asthmatics are more likely to be seen in the ambulatory setting if they are fee for service enrollees as compared to managed care. This may be due to differential reporting of encounter data by the plans as compared to the fee for service.
- Due to the importance of proper management of asthma in the primary care setting this indicator represents a significant opportunity for improvement in the delivery of care.

Quality Indicator 2. What percentage of asthmatics fill at least one prescription for a beta-agonist in a given calendar quarter?

Beta agonists are an inhaled short acting beta2-adrenergic agonist and the most effective drugs available for treatment of acute bronchospasm and prevention of exercise induced asthma. Inhaled short acting beta-agonists are recommended by NIH for all asthmatics as needed up to three times per day. Increased use indicates the need for oral steroids.

Numerator: All continuously enrolled and eligible identified asthmatics with at least one prescription for a beta-agonist.
Denominator: All continuously enrolled and eligible identified asthmatics.



Key findings:

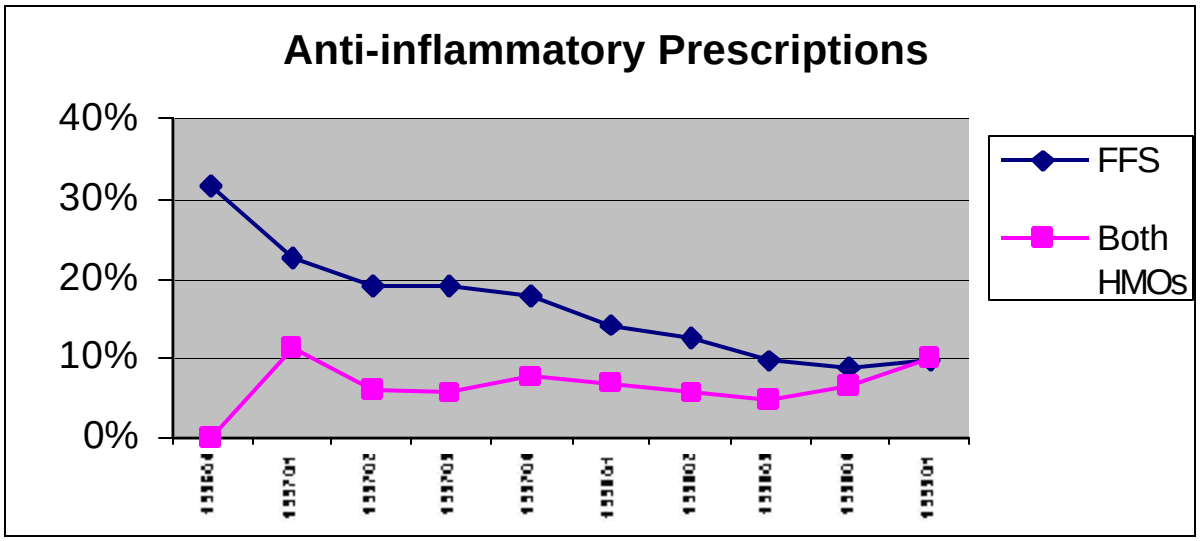
- Beta agonists are used at an increasingly similar rate in both the managed care and fee for service setting. Approximately 20% of identified pediatric asthmatics have at least one prescription for a beta agonist filled in a given calendar quarter. Wennberg working with a similar population of Medicaid pediatric asthmatics found an annual use rate of 80.8% for beta agonists. Although quarterly utilization is not additive to annual utilization rates (it over approximates the rate), the quarterly utilization rate of 20% is comparable to the use rate found in Maine by Wennberg.

Quality Indicator 3. What percentage of asthmatics fill at least one prescription for an anti-inflammatory drug during a given calendar quarter?

Anti-inflammatory drugs are a group including corticosteroids (inhaled or oral) and chromalyn sodium. Regular use of these drugs may suppress inflammation, decrease bronchial hyper-responsiveness and decrease symptoms in patients with persistent asthma. These drugs are recommended by the NIH for use in pediatric asthmatics with mild persistent and moderate persistent asthma.

Numerator: All continuously enrolled and eligible identified asthmatics with at least one prescription for an anti-inflammatory drug.

Denominator: All continuously enrolled and eligible identified asthmatics.



Key finding:

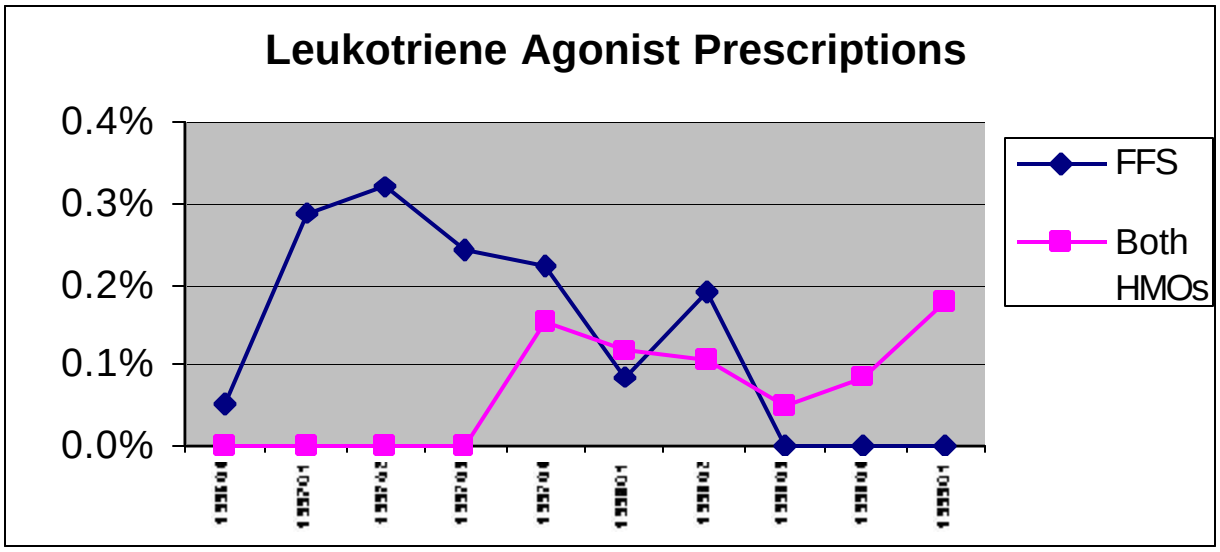
- Practitioners in the fee for service setting have historically prescribed more anti-inflammatory drugs for their pediatric asthmatics than their counterparts in the managed care setting. However managed care use of anti inflammatories has been increasing while fee for service use has been decreasing throughout the period of observation. In the first quarter of 1999, the most recent period examined there appears to be similar utilization between the two delivery types. The historical difference in utilization rates may simply represent differential reporting to the databases based on differing incentives, which was eliminated in the first quarter of 1999.

Quality Indicator 4. What percentage of asthmatics fill at least one prescription for a leukotriene antagonist in a given calendar quarter?

Leukotriene modifiers are a relatively new class of anti-asthmatic drug that are products or arachidonic acid metabolism that increase eosinophil migration, mucus production and airway wall edema and cause bronchoconstriction. This class of drugs has been found effective for maintenance treatment of asthma.

Numerator: All continuously enrolled and eligible identified asthmatics with at least one prescription for a leukotriene antagonist.

Denominator: All continuously enrolled and eligible identified asthmatics.



Key finding:

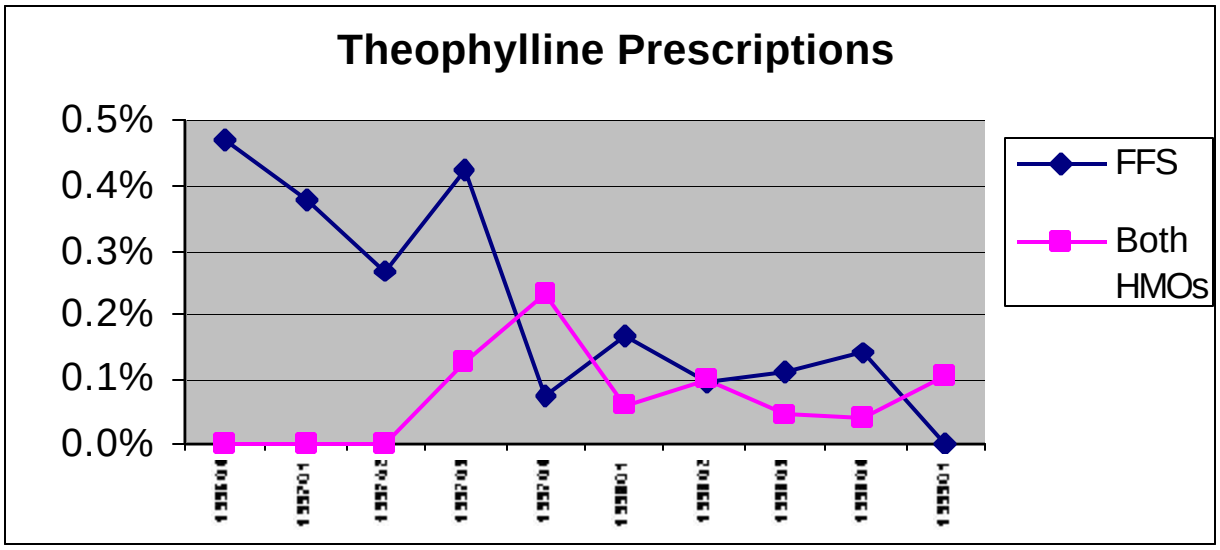
- Please note the change in the scale of the y-axis in this presentation of data. Use of leukotriene antagonists among Vermont pediatric asthmatics is still extremely limited and the fluctuations in the graph may be attributable to one or two prescriptions being filled for this new anti-asthma specific drug. The absolute number of asthmatics receiving this intervention is extremely low and therefore from a statistical perspective the difference is of limited importance.

Quality Indicator 5. What percentage of asthmatics has at least one prescription filled for theophylline in a given calendar quarter?

Theophylline is also a bronchodilator, although somewhat less effective than beta agonists it has a slower on set of action but may also have a modest anti-inflammatory effect. Theophylline has limited use for treatment of acute symptoms but can decrease the frequency and severity of symptoms in patients with persistent asthma, especially nocturnal asthma. Use of theophylline can decrease the need for inhaled corticosteroid. Theophylline is recommended for use by the NIH in concert with an inhaled steroid for children with moderate persistent asthma.

Numerator: All continuously enrolled and eligible identified asthmatics with at least one prescription for theophylline.

Denominator: All continuously enrolled and eligible identified asthmatics.



Key finding:

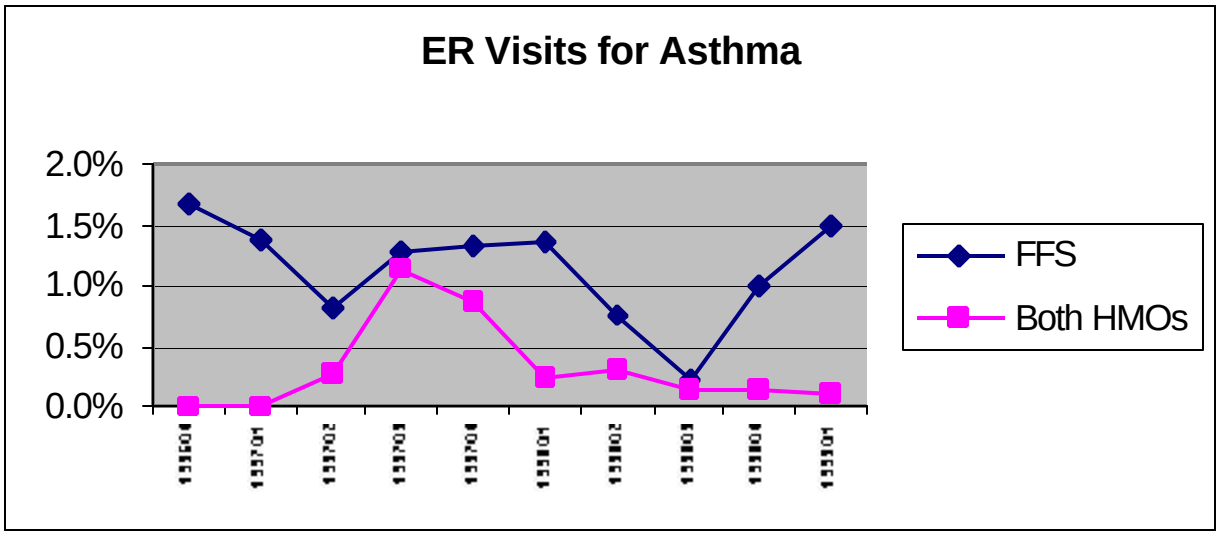
- The use of theophylline is extremely low as indicated in the significant reduction in the scale of the y-axis.

Quality Indicator 6. What percentage of asthmatics had at least one emergency room visit in a given calendar quarter?

The emergency department visit rate can be construed as a health outcome indicator. The measure looks at the rate at which identified asthmatics have at least one emergency room visit. Emergency room visits for asthma are avoidable with proper management in the ambulatory setting.

Numerator: All continuously enrolled and eligible identified asthmatics with at least one emergency room visit during the quarter.

Denominator: All continuously enrolled and eligible identified asthmatics.



Key finding:

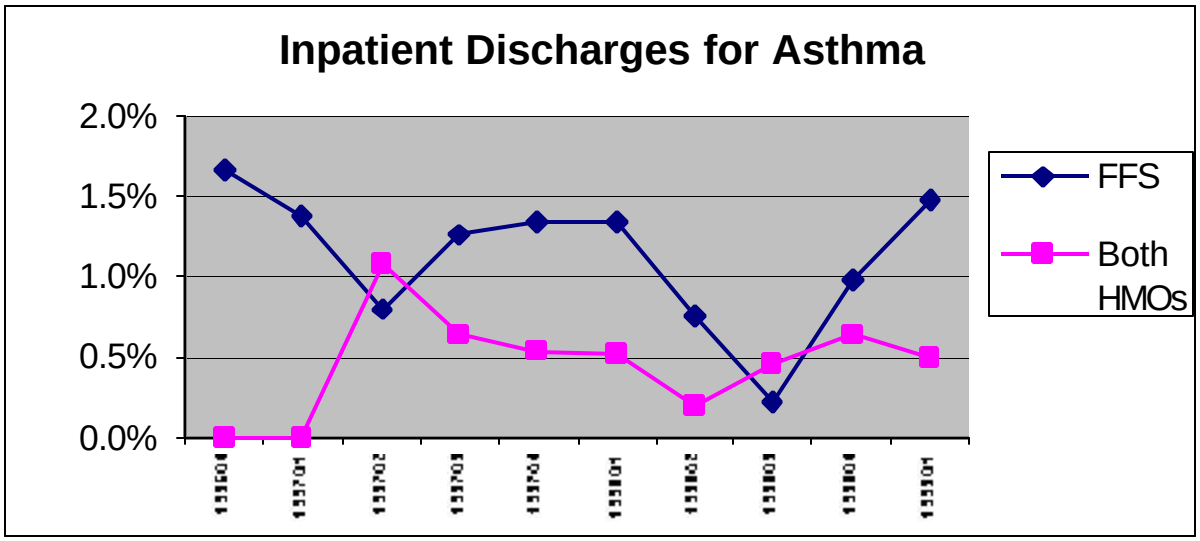
- Managed care enrollees utilize the emergency room less frequently than their fee-for-service counterparts. However, the rate of emergency room utilization for both the fee for service and managed care populations are extremely low, indicating that asthma is adequately managed in the acute care setting.

Quality Indicator 7. What percentage of asthmatics have at least one inpatient hospital stay in a given calendar quarter?

The final indicator, hospital inpatient utilization, can be construed a health outcome indicator. The measure looks at the rate at which identified asthmatics have at least one inpatient stay for asthma. Hospitalizations for asthma are avoidable with proper management in the ambulatory setting.

Numerator: All continuously enrolled and eligible identified asthmatics with at least one hospital encounter (emergency room visit or inpatient stay).

Denominator: All continuously enrolled and eligible identified asthmatics.



Key finding:

- Again the quarterly rate for identified asthmatics utilizing inpatient services is extremely low with the rate for managed care being consistently lower than the rate for those found in the fee for service setting. Managed care enrollees utilize hospital services less frequently than their fee-for-service counterparts. This finding was surprising since the managed care enrollees use fewer ambulatory services, fill fewer prescriptions for beta-agonists and anti-inflammatory drugs as compared to those in the fee for service setting.

EQRO Focused Study Brief:
Diabetes Care

Prepared by:

The Delmarva Foundation for Medical Care and
The Office of Vermont Health Access

This report presents an analysis of the Vermont Medicaid Administrative Database. The information presented here is based on a quarterly analysis (calendar quarters starting with the first quarter of 1996) of the experience of Vermont Medicaid beneficiaries that are enrolled for the entire quarter.

The data and information presented in this report are designed to facilitate continuous quality improvement efforts by the provider organizations. Indicators may not be comparable across plans and the fee-for-service setting because of differences in the population served (age structure, co-morbidities, and disease severity) that remain unaccounted for by the analysis.

The methodological approach presented in this document was developed by the Delmarva Foundation for Medical Care and the Office of Vermont Health Access. The specific definitions and quality indicators were derived from the Vermont Program for Quality in Health Care's 1998 Recommendation for Management of Diabetes in Vermont. The recommendations were developed with the assistance of a panel of Vermont Diabetes experts as part of a project coordinated by the Vermont Department of Health, funded by the Centers for Disease Control and Prevention.

Introduction

Diabetes is a highly prevalent condition (affecting 16 million Americans) that contributes enormously to morbidity. In 1997, it was the seventh leading cause of death, responsible for 2.7% of all deaths. Yet, diabetes is poorly treated and less than 30% of diabetics have their symptoms under control.

Performance Measures

The analyses conducted for this study will identify diabetics using the following criteria:

- One hospital discharge coded as diabetes (250.xx)

Or two ambulatory encounters (physician or clinic encounters) separated by 30 days but within four quarters coded for diabetes care (250.xx)

- Two ambulatory encounters coded diabetes (250.xx)

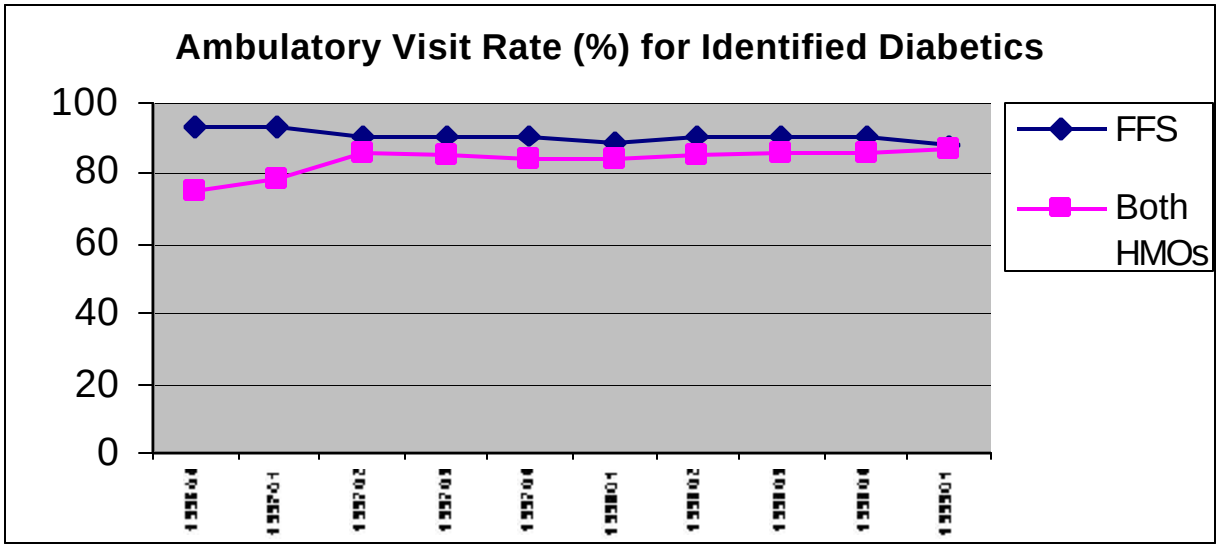
Vermont Program for Quality in Health Care's Recommendations for Management of Diabetes in Vermont form the basis for this evaluation. The Diabetes Care Quality Improvement Project compares the fee-for-service experience to the managed care experience by asking three questions about quality of care. Those questions are:

- How often do diabetics receive primary care (ambulatory) visits?
- How often do diabetics receive hemoglobin A1c tests?
- How often do diabetics receive dilated retinal exams?

Þ The assumption behind these questions is that appropriate use of ambulatory care and testing procedures will help control symptoms and identify potential complications at an early stage.

Quality Indicator 1. What percentage of diabetics have at least one primary care (ambulatory) encounter during a given calendar quarter?

Numerator: All continuously enrolled and eligible identified diabetics with at least one a ambulatory encounter for diabetes care (250.xx).
Denominator: All continuously enrolled and eligible identified diabetics.



Key finding:

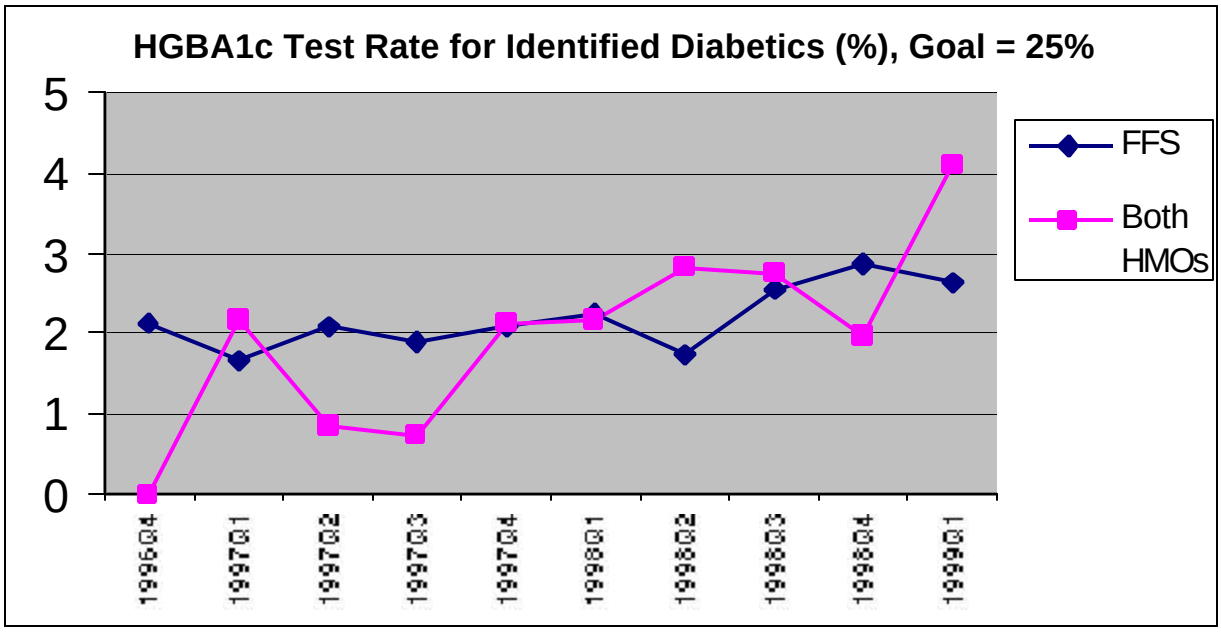
- Þ The rate of identified diabetics receiving care in the ambulatory setting on a quarterly basis is extremely high at approximately 90%.
- Þ Fewer identified diabetics in the managed care setting had an ambulatory encounter as compared to beneficiaries in the fee for service setting. However, over 80% of the identified diabetics had an ambulatory encounter in any given quarter during the period of observation. This is indicative of a high degree of ongoing care for this chronic condition.
- Þ There is no benchmark level for this particular quality indicator.

Quality Indicator 2. What percentage of diabetics has at least one hemoglobin A1c test during a given calendar quarter?

HbA1c testing measures the level of a group of stabile minor hemoglobin components, glycated hemoglobin, formed slowly and non-enzymatically from hemoglobin and glucose. Therefore it is a composite or long-term average measure of blood sugar levels that is less susceptible to daily fluctuations. "Recommendations for Management of Diabetes in Vermont" recommends that diabetics receive a HbA1c test once every 3 to 6 months.

Numerator: All continuously enrolled and eligible identified diabetics with at least one hemoglobin A1c test.

Denominator: All continuously enrolled and eligible identified diabetics.



Benchmark: The Vermont Department of Health and VPQHC Diabetes management guidelines indicate the ideal rate of HbA1c testing would be each diabetic receiving at least one test every six months. Because the indicator above measures the quarterly testing rate the ideal quarterly rate would be 50%.

Key finding:

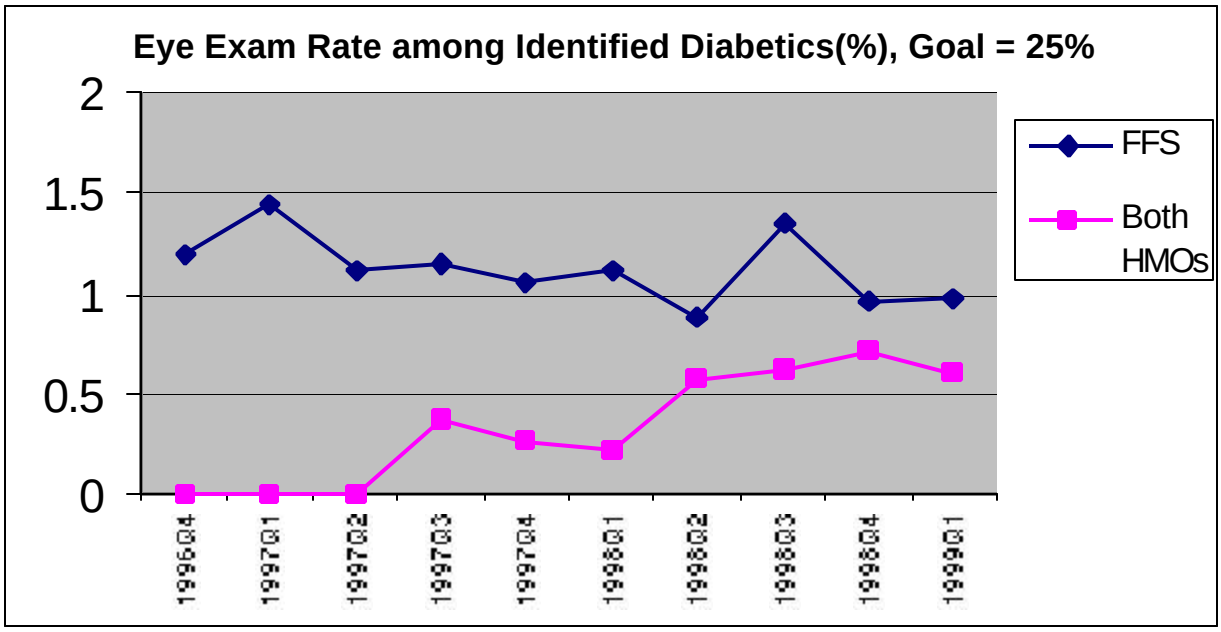
- The average quarterly rate of HbA1c testing in diabetics is approaching 3%, indicating a large potential for improvement relative to the 50% desired level.
- Managed care appears to be doing as well as fee for service and appears to be trending up relative to fee for service.

Quality Indicator 3. What percentage of diabetics have at least one dilated retinal exam during a given calendar quarter?

Diabetic retinopathy is strongly correlated with the duration of diabetes and may result in blindness. Patients with vision threatening retinopathy may not have symptoms. Laser photocoagulation may prevent loss of vision in most patients. Vermont's Department of Health recommends type 2 diabetics receive annual eye exams and type 1 diabetics receive annual exams 3 to 5 years following diagnosis.

Numerator: All continuously enrolled and eligible identified diabetics with at least one dilated eye exam.

Denominator: All continuously enrolled and eligible identified diabetics.



Benchmark: The Vermont Department of Health recommends that all diabetics (except type I diabetics recently diagnosed) receive an annual eye exam. Therefore the expected quarterly rate for eye exam among identified diabetics would be 25%.

Key finding:

- The average quarterly rate of eye exam among diabetics is less than 1%, indicating a large potential for improvement relative to the 25% desired level.
- Managed care's rate of eye exam among identified asthmatics is consistently less than the experience of beneficiaries in the fee for service setting.

Opportunities for Follow-up and Improvement

1. Improve rates of HbA1c testing among identified diabetics.
2. Improve rates of dilated eye exams among identified diabetics